PERFORATED GASTRIC ULCER

"FORME FRUSTE" TYPE—WITH SUPRADIAPHRAGMATIC DRAINAGE OF THE LOCALIZED ABSCESS

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THE case report below is made because of the following points of interest:

1. An apparent "forme fruste" type (H. A. Singer, M. D., R. T. Vaughan, M. D.) of perforated gastric ulcer in which surgery was refused.
2. Apparent spontaneous recovery, followed by: (*a*) A localized subdiaphragmatic abscess and pleural effusion; (*b*) surgical supradiaphragmatic drainage of the abscess.
3. Postoperative lung fistula.
4. Complete recovery.

REPORT OF CASE

Mr. M. S., age thirty-four years, a Japanese laborer, was first seen on June 27, 1932, in answer to an emergency call, sitting up in his bed with thighs flexed on abdomen and in apparent extreme pain. He was perspiring freely, his body cool and clammy, but the pulse was fairly good and there was no extreme shock. His temperature was 97.4 degrees orally. The abdomen was board-like with rigidity and extremely tender on palpation. It was necessary to give him one-quarter grain of morphin before he could be removed to the hospital.

Radiographs taken soon after admission to the hospital showed a small bubble of air under the left dome of the diaphragm (taken with the patient in erect position).

It was difficult to obtain a very detailed history as a satisfactory interpreter was not to be had. Apparently the patient had had some stomach trouble of an indefinite nature for a long time. Two days previous to this acute illness a sharp pain occurred in the upper part of his abdomen and lower right side. This was aggravated by lying down. He had several such attacks of severe pain with sweats, but was able to continue work in the lettuce fields until 10 a. m. of June 27, when he had to stop because of a severe abdominal pain. He applied hot packs, but by 2 p. m. the pain became so severe that medical attention was sought. There was no vomiting or nausea and no fever that he was aware of.

His past history was negative as far as could be ascertained. He had always enjoyed good health until the above stomach distress began. He drank heavily and was off work for two months following one of these orgies.

A diagnosis of a ruptured gastric ulcer was made and immediate surgery advised. This was refused, so the usual medical treatment was instituted. That evening his temperature rose to 100 degrees. No further doses of morphin were needed for pain until early next morning. The pain at this time was mostly confined to the upper abdomen. Pain was easily controlled by small doses. On the second day his fever ranged from 99.6 to 101.2 degrees. The pulse remained good. On the third day there was tenderness in the lower right quadrant with rebound tenderness, and less distress in the upper abdomen. The patient, however, did not either look or feel bad. Abdominal distention was only very slight. The white blood count reached 24,000. On the fourth day he complained of pain in his chest. A few crackles could be heard in the lower left base, laterally. His temperature ranged from 98.4 to 99.2 degrees. On the next day he felt fine and there was only a faint tenderness in his abdomen. From now on he progressed very favorably, complaining only occasionally of a slight distress near the lower left sternal margin. In order to avoid expense he was discharged from the hospital on July 5, to report to the office every few days.

On July 12 he complained of a pleurisy-like pain in the left shoulder and lower left costal region. No râles could be heard in the chest and his temperature remained normal. Three days later he came to the office feeling very ill and with pain in the left lower chest. He was weak and perspiring freely. His temperature was 102.2 degrees. There was dullness in the lower half of the chest, with absent breath sounds. He was sent to the hospital, where an exploratory puncture was made in the tenth interspace, posterior axillary line. The needle was felt to penetrate more than pleura. Thick, yellow-green pus was aspirated.

On the following day he was taken to surgery. A preliminary exploration with the needle gave only straw-colored fluid. We now felt certain that the pus had been obtained after puncturing the diaphragm, and that the fluid was confined to the pleural cavity. A section of the tenth rib was resected, and further exploration with the needle through the diaphragm located pus. The wound was packed with gauze so as to stimulate adhesions and thereby wall off the pleural cavity before attempting to drain the abscess. This was done two days later. The infection was found to be well walled off and could be freely opened and drained through the diaphragm. Two rubber tube drains were inserted. Postoperative recovery was uneventful except for the development of a lung fistula, apparently due to pressure from one of the tubes. This closed spontaneously in two weeks.

Radiographs and fluoroscopic examination of the chest and stomach did not reveal any pathology on August 16. The patient was discharged in excellent condition.

COMMENT

Clinically this case fits in with the "forme fruste" type of perforated gastric ulcer as described by H. A. Singer and R. T. Vaughan. There were several days of prodromal symptoms: pain and epigastric tenderness. The pain of rupture was not quite as excruciating and the shock not as great as the classical form. The presence of air under the diaphragm offered our most definite diagnostic sign. The initial symptoms subsided rapidly. At no time was abdominal tympanites marked.

If our first exploratory puncture of the chest had not located the pus on first trial, but the pleural effusion instead, valuable time might have been lost in taking the proper surgical steps. Fortunately the pleura was not infected by withdrawal of the needle. The value of the two-stage operation in order to avoid infecting the pleural cavity is self-evident.

We feel that the end-result is most gratifying, as verified by radiographic evidence as well as clinically. The fact that no gastric lesion was demonstrated radiographically was not surprising, as it has been demonstrated by others that ulcerative lesions have healed completely following rupture.

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